HOPE ALIVE ~ INTAKE FORM

This form is intended to help your counselor become better acquainted with you and, in turn, serve you better. ***Please print*** *the information requested or checkmark the appropriate responses. You may omit any item but try to be as thorough as possible. Thank you.*

Name _____ Today's Date: _____

Birthdate _____ Age: _____ Marital Status: S / M / D / W

Address _____ City _____ Zip _____

Phone _____ Messages: Okay voicemail ___ Ok other person ___ no messages ___

Referred By:_____

Emergency Contact Information

Name _____ Relationship _____

Address _____ City _____ Zip _____

Phone _____ Messages: Okay voicemail ___ Ok other person ___ no messages ___

List Others Living in the Home, and all children

Name	Relationship	Age

Presenting Problem

Briefly describe why you are seeking counseling: _____

_____

_____

_____

How would you rate the intensity of the problem or concern that let you to seek counseling? (please circle)

Extremely Intense — Moderately Intense — Not Intense

5 4 3 2 1

Approximately how long have you had this current problem or concern? _____

What would you like do accomplish in therapy?

1. _____
2. _____
3. _____

Cultural Background

What is your race/ethnicity?

___ White
___ Asian American
___ Black/African American
___ Native Hawaiian/Pacific Islander
___ Hispanic/Latino
___ American Indian/Alaskan Native
___ Multiracial (please specify)_____
___ International (please specify) _____

How much do you identify with your ethnic heritage __not at all__a little__somewhat __strongly

Social Background

Please describe any relationships in your family and/or social network that are significant sources of stress or conflict for you:_____

_____

_____

Please list those individuals (name/relationship) who are a source of emotional support to you:

_____

_____

Education and Occupational Information

Please indicate your educational level:

___ Less than high school
___ H.S. equivalent/GED
___ High School Diploma
___ Vocational
___ Some College (no degree completed)
___ Bachelor's Degree
___ Master's Degree
___ Doctoral Degree
___ Other

Are you currently employed? ___ no ___ yes Are you currently in school? ___ no ___yes

If yes, who is your currently employer/position/school? _____

Please list any work/school-related stressors, if any _____

_____

Religious/Spiritual Information

Do you consider yourself to be religious? ___ yes ___ no

If yes, what are your faith/spiritual beliefs and how do they impact your daily life? _____

_____

Have you ever been hurt by someone related to religious or church issues? ___ yes ___ no

Church Affiliation: _____

Would you like Christian faith to be included in the counseling process? ___ yes ___ no

Primary Care Physician and Health History

Name _____ Phone _____

Address _____ City _____ Zip _____

How would you rate your overall health at present? ___ poor ___ fair ___ good ___ excellent

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

_____

Please list any medications you are currently taking, the dosage, and the condition they treat:

_____

_____

Do you currently drink alcohol? ___ yes ___ no

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

___ daily ___ weekly ___ monthly ___ rarely ___ never

How often do you currently engage in recreational drug use?

___ daily ___ weekly ___ monthly ___ rarely ___ never

Do you smoke cigarettes/e-cigarettes or use other tobacco products? ___ yes ___ no

If yes, how much to you smoke? _____

If your alcohol, drug, or tobacco consumption was different in the past compared to now, please describe your past use (when, how much, how often). _____

_____

Mental Health History

Have you had previous counseling? ___no ___ yes, Please describe previous experience (How long ago? Was it positive or negative? What was helpful/unhelpful? Etc.) : _____

_____

Has anyone in your family (either immediate family members or relatives) experienced difficulties with mental health? ___ no ___ yes If yes, please describe: _____

Have you had suicidal or homicidal thoughts recently?

___ frequently ___sometimes ___rarely ___never

Have you had them in the past?

___ frequently ___sometimes ___rarely ___never

Please place a check mark next to any item which you have experienced, either currently or in the past.

alcohol use		feeling overemotional		sexual function problems	
angry mood		race/ethnicity/cultural concerns		seeing strange things	
anxiety or fearfulness		grief/death of a loved one		significant weight change	
bingeing/purging		hearing strange voices		sleeping more or less than usual	
change in appetite		guilt		social isolation	
confusion		hopelessness		suicidal thoughts	
depressed mood		hyperactivity		homicidal thoughts	
drug use		irritability		non-suicidal self-harm	
elevated mood		laxative/diuretic use		compulsive behaviors	
parenting problems/DCS involvement		mood swings		poor concentration	
loss of interest in things		obsessive thoughts		relationship conflicts	
restricted eating		panic attacks		racing thoughts	
emotionally harmed by others		victim of physical harm		loss of motivation for things	
medical problems		struggling with hygiene		past suicide attempts	
fatigue/low energy		sexually harmed by others		unemployment	
nightmares		problems falling or staying asleep		financial stressors	
frequent relocations or homelessness		marital problems		legal problems/incarceration/ probation	

Assets and Strengths

What are your special interests and hobbies? _____

_____

_____

What do you see as your personal strengths? _____

_____

_____

What values are important to you? _____

_____

Is there anything else you want me to know about you? _____

_____

_____

FOR OFFICE USE

Client is a: ___ Resident ___ Non-resident

Counselor's Name (please print): _____ Counselor's Initials: _____

Clinical focus/impressions: _____

_____

Fee Amount Agreed Upon: _____